**MISSOURI**

**DIVISION OF MEDICAL SERVICES**

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# HOSPITAL BULLETIN

**Provider Bulletin News:** Due to budget constraints, paper copies of bulletins will no longer be distributed by DMS. Bulletins are now available only at the DMS Website. http://www.dss.mo.gov/dms/pages/bulletins.htm Please note new website address.

Bulletins will remain on this site only until incorporated into the provider manuals as appropriate, then deleted.

**Missouri Medicaid News:** Missouri Medicaid providers may sign-up to receive automatic notifications of all bulletins and other official Missouri Medicaid communications via e-mail. Providers and other interested parties are urged to go the DMS website to subscribe to the e-mail list.

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## MC+ MANAGED CARE

The information contained in this bulletin applies to coverage by the MC+ fee-for-service and Medicaid fee-for-service programs. The MC+ fee-for-service and Medicaid fee-for-service programs also provide coverage for those services carved out of the MC+ Managed Care benefit for MC+ Managed Care enrollees. Questions regarding services included in the MC+ Managed Care benefit should be directed to the enrollee's MC+ Managed Care health plan. Please check the patient's eligibility status prior to delivering a service.

## HIPAA

To prepare for the October 16, 2003 mandatory implementation of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) national standards, Missouri Medicaid has analyzed how providers must bill for services in order to be in compliance with the implementation of national transaction and code sets.

HIPAA mandates the use of standard Health Care Procedure Coding System (HCPCS) code sets; however, it does *not* require states to add coverage for services that it does *not* currently cover.

Billing providers wishing to exchange electronic transactions with Missouri Medicaid may now view the X12N Version 4010A1 Companion Guide on Missouri Medicaid's web page at http://www.medicaid.state.mo.us. To access the Companion Guide, select Missouri Medicaid Electronic Billing Layout Manuals; select System Manuals; select Electronic Claims Layout Manuals; select X12N Version 4010A1 Companion Guide. For information on Missouri Medicaid's Trading Partner Agreement, select Section 1 - Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

Billing providers wishing to exchange electronic pharmacy transactions with Missouri Medicaid may now view the NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide on Missouri Medicaid's web page at http://www.medicaid.state.mo.us. To access the Companion Guide select Missouri Medicaid Electronic Billing Layout Manuals; select Systems Manuals; select Electronic Claims Layout Manuals; select NCPDP Telecommunication V.5.1 and Batch Transaction Standard V.1.1 Companion Guide. For information on Missouri Medicaid's Trading Partner Agreement, select Section 1 - Getting Started; select Trading Partner Registration. All questions concerning Trading Partner Agreements or provider testing schedules should be directed to the Verizon Help Desk at 573-635-3559.

With implementation of HIPAA national standards by Missouri Medicaid, the following non-HIPAA compliant methods of electronic claims submission will be phased out and will no longer be available for use by providers:

- Accelerated Submission and Processing (ASAP) System
- Bulletin Board System (BBS)
- Direct Electronic File Transfer (DEFT)
- Direct Electronic Medicaid Information (DEMI)
- Magnetic Tape Billing (MTB)

The existing formats and media will be available during a short grace period for providers unable to produce a HIPAA-compliant 837 professional transaction starting October 16, 2003. Providers may continue to bill current Missouri Medicaid formats and media during this grace period.

All providers wishing to bill Missouri Medicaid in paper format should refer to Section 15 – Billing Instructions Physicians for paper claim filing instructions.

## TYPE OF SERVICE

With the implementation of HIPAA national standards on October 16, 2003, type of service will no longer be a valid code set. Type of service *must not* be included on any type of claim submission (other than the non-HIPAA compliant formats and media as defined above) on or after October 16, 2003, regardless of the date of service being billed. In order to make up for the loss of type of service, claims submitted to Missouri Medicaid must reflect an appropriate modifier with a procedure code when billing for the services defined below. For example, prior

to October 16, 2003, when billing for an assistant surgeon's services, a procedure code is submitted with type of service 8. Effective on or after October 16, 2003, when billing for an assistant surgeon's service, a procedure code must be submitted with modifier '80'. Failure to do so may result in claim denial.

| Modifier | Definition |
|---|---|
| 26 | Professional Component |
| 54 | Surgical Care Only |
| 55 | Postoperative Management Only |
| 80 | Assistant Surgeon |
| AA | Anesthesia service performed personally by anesthesiologist |
| NU | New Equipment (required for DME service) |
| QK | Medical direction of 2, 3 or 4 concurrent anesthesia procedures involving qualified individuals |
| QX | CRNA service; with medical direction by a physician |
| QZ | CRNA service; without medical direction by a physician |
| RP | Replacement and Repair (required for DME service) |
| RR | Rental (required for DME service) |
| SE | State and/or federally funded programs/services |
| SG | Ambulatory Surgical Center (ASC) facility services |
| TC | Technical Component |
| UC | EPSDT Referral for Follow-up Care (required if EPSDT referral made) |

Providers who continue to bill claims to Missouri Medicaid using one of the non-HIPAA compliant electronic formats or media, as stated under the HIPAA Section of this Bulletin, should continue to bill using the appropriate type of service.

## INPATIENT HOSPITAL SURGICAL PROCEDURE CODES

The International Classification of Diseases, 9th Revision, Clinical Modification, (ICD-9-CM) procedure codes are required by HIPAA standards to be used to report surgical procedures on the inpatient hospital claim form. ICD-9-CM procedure codes must be used on any type of inpatient hospital claim submissions on or after October 16, 2003. Do not use the decimal point when entering the code on any claim type. Please refer to Attachment A for a list of Missouri Medicaid restrictions concerning this standard code set.

## OUTPATIENT HOSPITAL SURGICAL PROCEDURE CODES

The Current Procedural Terminology (CPT) codes will continue to be used to report surgical procedures on any type of outpatient hospital claim submission on or after October 16, 2003.

## REHABILITATION SCHEDULE

Effective October 16, 2003 inpatient rehabilitation providers subject to DMS established length of stay will no longer reference the special diagnosis codes created by DMS to report the rehabilitation diagnosis. The following table reflects the ICD-9-CM diagnosis codes that will be used to report the rehabilitation diagnosis:

| DESCRIPTION | DMS ESTABLISHED LENGTH OF STAY | DELETED SPECIAL DIAGNOSIS CODE | ICD-9-CM DIAGNOSIS CODE(S) |
|---|---|---|---|
| Spinal cord injury, quadriplegia | 30 days | SC1 | 950 - 957 |
| Spinal cord injury, cervical fracture | 25 days | SC2 | 806 |
| Spinal cord injury, paraplegia | 30 days | SC3 | 344 |
| Spinal cord injury, hemiplegia | 25 days | SC4 | 342 |
| Cerebral vascular accident | 29 days | CVA | 436 |
| Head trauma | 35 days | HTI | 803, 854 |
| Muscular dystrophy | 20 days | MUD | 359 |
| Orthopedic trauma, arm | 29 days | OT1 | 885 - 887 |
| Orthopedic trauma, leg | 29 days | OT2 | 895 - 897 |
| Late effect of injury to the nervous system | 30 days | ENS | 905 - 909 |
| Degenerative joint disease | 20 days | DJD | 714 - 716 |

For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific diagnosis codes.

## SOLID ORGAN AND BONE MARROW TRANSPLANT CLAIM SUBMISSION

There will be no change in claim processing for solid organ and bone marrow transplant claims at this time. However, ICD-9-CM surgical procedure codes will be required on all inpatient hospital transplant claims for claim submissions on or after October 16, 2003.

## OUTPATIENT HOSPITAL FACILITY CODES

Effective October 16, 2003 outpatient hospital providers must use the appropriate covered facility revenue codes listed below. Only the revenue codes listed in this bulletin will be recognized on the outpatient hospital claim.

| FACILITY CODE DESCRIPTION | DELETED LEVEL III CODE | REPLACEMENT REVENUE CODE |
|---|---|---|
| Outpatient Clinical: Non-surgical | X4003 | 0510 |
| Outpatient Clinical: Surgical | X4006 | 0490 |
| Emergency Room: Non-surgical | X4011 | 0450 |
| Emergency Room: Surgical | X4014 | 0459 |
| Medical Supplies | Y7506 | 0270 |
| Surgical Supplies | Y7509 | 0270 |
| Blood/ IV Supplies | Y7507 | 0260, 0390 |
| Orthopedic Supplies | Y7508 | 0274 |
| On-Site Oral Medication | J7140 | 0250 |
| Observation Room, 1 to 5 hours | Y3114 | 0762, Quantity of 1 |
| Observation Room, 6 to 11 hours | Y3115 | 0762, Quantity of 2 |
| Observation Room, 12 to 17 hours | Y3116 | 0762, Quantity of 3 |
| Observation Room, 18 to 24 hours | Y3117 | 0762, Quantity of 4 |

For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers.

## OUTPATIENT EMERGENCY SERVICES EXEMPT FROM COST SHARING

Effective October 16, 2003, Condition Code AJ must be used on the outpatient claim in order to properly identify emergency services that are exempt from the cost sharing requirement. This will replace the X01 diagnosis code previously used. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific diagnosis codes.

When emergency services are provided in an outpatient setting, only one date of service may be shown on the claim.

When billing Missouri Medicaid, indicate the usual and customary charge for the service as the billed amount in the charge column. Do not deduct the recipient's cost sharing amount from the billed charge and do not show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the cost sharing amount, thus determining the correct payable amount.

## OUTPATIENT THERAPY SERVICES EXEMPT FROM COST SHARING

Effective October 16, 2003, Condition Code AJ must be used on the outpatient claim in order to properly identify therapy services that are exempt from the cost sharing requirement. This will replace the X02 diagnosis code previously used. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific diagnosis codes.

When billing Missouri Medicaid, indicate the usual and customary charge for the service as the billed amount in the charge column. Do not deduct the recipient's cost sharing amount from the billed charge and do not show it as an amount paid or as another source payment. The claims processing system calculates the maximum allowable fee and automatically deducts the cost sharing amount, thus determining the correct payable amount.

## HCPCS INJECTION CODES

Effective October 16, 2003 HCPCS injection codes not compliant with HIPAA standard code sets will be invalid. Those codes include injection codes beginning with "W" and "Z" and J-codes when used with modifiers YA, YB, YC, and YD. An injection with a J-code that is not payable under Missouri Medicaid cannot be billed under Revenue Code 0270 (Medical Supplies). J-Codes not payable on or after October 16, 2003 include all DME J-Codes. All other J-codes are payable effective October 16, 2003. For dates of service prior to October 16, 2003, providers should continue to bill using the appropriate Missouri Medicaid-specific procedure codes/modifiers.

**Provider Communications**

**(800) 392-0938**
**or**
**(573) 751-2896**

Attachment A

| ICD-9 Procedure Code | Restriction |
|---|---|
| 05.23 | Certificate of Medical Necessity Required |
| 08.31 | Prior Authorization Required |
| 08.32 | Prior Authorization Required |
| 08.33 | Prior Authorization Required |
| 08.34 | Prior Authorization Required |
| 08.35 | Prior Authorization Required |
| 08.36 | Prior Authorization Required |
| 08.37 | Prior Authorization Required |
| 08.7 | Prior Authorization Required |
| 08.86 | Prior Authorization Required |
| 08.87 | Prior Authorization Required |
| 11.71 | Not Covered |
| 11.75 | Not Covered |
| 11.76 | Prior Authorization Required |
| 16.98 | Not Covered |
| 18.01 | Not Covered |
| 18.5 | Prior Authorization Required |
| 21.83 | Not Covered |
| 21.84 | Not Covered |
| 21.86 | Not Covered |
| 21.87 | Not Covered |
| 24.2 | Not Covered |
| 24.39 | Not Covered |
| 24.5 | Not Covered |
| 32.22 | Not Covered |
| 33.5 | Transplant Contract Required |
| 33.51 | Transplant Contract Required |
| 33.52 | Transplant Contract Required |
| 33.6 | Transplant Contract Required |
| 37.5 | Transplant Contract Required |
| 38.99 | Not Covered |
| 39.92 | Not Covered |
| 41.0 | Transplant Contract Required |
| 41.01 | Transplant Contract Required |
| 41.02 | Transplant Contract Required |
| 41.03 | Transplant Contract Required |
| 41.04 | Transplant Contract Required |
| 41.05 | Transplant Contract Required |
| 41.06 | Transplant Contract Required |
| 41.07 | Transplant Contract Required |
| 41.08 | Transplant Contract Required |
| 41.09 | Transplant Contract Required |

| ICD-9 Procedure Code | Restriction |
|---|---|
| 41.91 | Transplant Contract Required |
| 41.98 | Transplant Contract Required |
| 44.31 | Prior Authorization Required |
| 44.50 | Prior Authorization Required |
| 44.69 | Prior Authorization Required |
| 45.63 | Transplant Contract Required |
| 46.97 | Transplant Contract Required |
| 50.22 | Transplant Contract Required |
| 50.4 | Transplant Contract Required |
| 50.51 | Transplant Contract Required |
| 50.59 | Transplant Contract Required |
| 52.59 | Transplant Contract Required |
| 52.6 | Transplant Contract Required |
| 52.82 | Transplant Contract Required |
| 52.84 | Transplant Contract Required |
| 52.99 | Transplant Contract Required |
| 55.61 | Transplant Contract Required |
| 55.69 | Transplant Contract Required |
| 59.5 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 62.7 | Not Covered |
| 62.99 | Not Covered |
| 63.73 | Sterilization Consent Form Required |
| 64.43 | Not Covered |
| 64.5 | Not Covered |
| 64.93 | Prior Authorization Required |
| 64.95 | Not Covered |
| 64.96 | Not Covered |
| 64.97 | Not Covered |
| 64.98 | Prior Authorization Required |
| 64.99 | Not Covered |
| 65.31 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.39 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.41 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.49 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.51 | Acknowledgement of Receipt of Hysterectomy Form Required |

| ICD-9 Procedure Code | Restriction |
|---|---|
| 65.52 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.53 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.54 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.61 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.62 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.63 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 65.64 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 66.02 | Not Covered |
| 66.21 | Sterilization Consent Form Required |
| 66.22 | Sterilization Consent Form Required |
| 66.29 | Sterilization Consent Form Required |
| 66.31 | Sterilization Consent Form Required |
| 66.32 | Sterilization Consent Form Required |
| 66.39 | Sterilization Consent Form Required |
| 66.72 | Not Covered |
| 66.73 | Not Covered |
| 66.74 | Not Covered |
| 66.79 | Prior Authorization Required |
| 66.8 | Prior Authorization Required |
| 66.92 | Sterilization Consent Form Required |
| 66.95 | Prior Authorization Required |
| 66.96 | Prior Authorization Required |
| 68.3 | Sterilization Consent Form Required |
| 68.4 | Sterilization Consent Form Required |
| 68.51 | Sterilization Consent Form Required |
| 68.59 | Sterilization Consent Form Required |
| 68.6 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 68.7 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 68.8 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 68.9 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 69.01 | Certificate of Medical Necessity for Abortion Required |
| 69.51 | Certificate of Medical Necessity for Abortion Required |
| 69.92 | Not Covered |
| 69.93 | Certificate of Medical Necessity for Abortion Required |
| 69.99 | Certificate of Medical Necessity for Abortion Required |
| 70.4 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 70.79 | Prior Authorization Required |
| 70.8 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 70.92 | Acknowledgement of Receipt of Hysterectomy Form Required |
| 71.4 | Prior Authorization Required |
| 71.9 | Not Covered |
| 74.91 | Certificate of Medical Necessity for Abortion Required |
| 75.99 | Certificate of Medical Necessity for Abortion Required |
| 76.68 | Prior Authorization Required |
| 78.9 | Prior Authorization Required |
| 78.91 | Prior Authorization Required |
| 78.92 | Prior Authorization Required |
| 78.93 | Prior Authorization Required |
| 78.94 | Prior Authorization Required |
| 78.95 | Prior Authorization Required |
| 78.96 | Prior Authorization Required |
| 78.97 | Prior Authorization Required |
| 78.98 | Prior Authorization Required |
| 78.99 | Prior Authorization Required |
| 82.82 | Prior Authorization Required |
| 82.83 | Prior Authorization Required |
| 83.29 | Not Covered |
| 83.92 | Prior Authorization Required |

| ICD-9 Procedure Code | Restriction |
|---|---|
| 85.2 | Prior Authorization Required |
| 85.31 | Prior Authorization Required |
| 85.32 | Prior Authorization Required |
| 85.33 | Prior Authorization Required |
| 85.35 | Prior Authorization Required |
| 85.5 | Prior Authorization Required |
| 85.51 | Prior Authorization Required |
| 85.52 | Prior Authorization Required |
| 85.53 | Prior Authorization Required |
| 85.54 | Prior Authorization Required |
| 85.6 | Prior Authorization Required |
| 85.7 | Prior Authorization Required |
| 85.85 | Prior Authorization Required |
| 85.87 | Prior Authorization Required |
| 85.93 | Prior Authorization Required |
| 85.94 | Prior Authorization Required |
| 85.95 | Prior Authorization Required |
| 85.96 | Prior Authorization Required |
| 85.99 | Prior Authorization Required |
| 86.02 | Prior Authorization Required |
| 86.05 | Prior Authorization Required |
| 86.25 | Prior Authorization Required |
| 86.64 | Not Covered |
| 86.82 | Not Covered |
| 86.83 | Prior Authorization Required |
| 86.92 | Not Covered |
| 86.93 | Prior Authorization Required |
| 87.85 | Prior Authorization Required |
| 89.04 | Not Covered |
| 96.17 | Not Covered |
| 96.49 | Certificate of Medical Necessity for Abortion Required |
| 97.24 | Not Covered |
| 97.71 | Not Covered |
| 99.86 | Prior Authorization Required |
| 99.96 | Not Covered |
| 99.99 | Prior Authorization Required |